POC #2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OCT 10/1/11

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
acceptable	445254	A. BUILDING _____ B. WING _____	C 08/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA NURSING AND REHAB CENTER	18805 ALBERTA DR ONEIDA, TN 37841

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	1. Administrator and Director of Nurses was inservived on "Falls Management" and "Events Management" Policy and Procedure by the Regional Director of Clinical Services on 8/18/2011. Completed investigation on 8/19/2011 by the Regional Director of Clinical Services, Administrator, Director of Nurses, and Social Services. Physician orders, Nurse Assessments, Care Plans, MDS's were reviewed and plans of action were documented by Director of Nurses, Assistant Director of Nurses and Minimum Data Set Coordinator on 8/19/2011. Administrator, Director of Nurses and Social Services met with family conservator on 8/19/2011 to review the care plan and no issues or concerns noted. Physician completed assessment on 8/24/2011 and no adverse effects were identified. 2. 100% audit of all incident reports from 7/11/2011 until 8/11/2011 were reviewed for completeness by the Regional Director of Clinical Services, Director of Nurses and Assistant Director of Nurses on 8/19/2011.	10/1/2011

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela K. Chitwood
TITLE: Administrator
(X6) DATE: 9-1-2011

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Medical record review revealed the resident was readmitted to the facility on September 22, 2010, with diagoses including Hemplegia Dominant Side, Heart Failure, and Dementia. Medical record review of a physician's order dated September 22, 2010, revealed, "bed in lowest position while in bed..." Medical record review of the Minimum Data Set (MDS) dated June 23, 2011, revealed a Brief Interview for Mental Status score of 3 and a score of 0-7 represented severely impaired mental status. Continued review revealed the resident was sometimes able to express (resident's) needs and responded adequately to simple direct communication only, was free of behavioral problems, and totally dependent on staff for activities of daily living. Continued review revealed the resident had no history of falls since readmission or the prior MDS assessment. Medical record review of a Fall Risk Assessment dated June 16, 2011, revealed a score of 16 and a score of 10 or greater was high risk. Medical record review of a care plan revised June 16, 2011, revealed, "Potential for falls...eval (evaluate) cause of prev (previous) falls and implement appro (appropriate) interventions..." Medical record review of a nurse's note dated July 13, 2011, at 1:59 p.m., revealed, "...found in floor...Bedside table beside (resident) with bright red blood noted to the floor. Large hematoma noted to right brow..." Continued review revealed the resident was transported to an emergency room. Medical record review of a nurse's note	F 225	3. Inservice was conducted 8/18/2011 thru 8/23/2011 by the Director of Nurses for Registered Nurses, Licensed Practical Nurses, Certified Nurse Aides, Dietary, Housekeeping, Laundry, Activities, Maintenance and Business Office on "Falls Management" and "Events Management" Policy and Procedure. All incidents are reviewed per "Fall Management" and "Events Management" Policy and Procedure in AM clinical meeting daily Monday through Friday and weekly at "At Risk Meeting" which is attended by Administrator, Director of Nurses, Social Services, Activities, Minimum Data Set Coordinator, Dietary, Medical Records and Rehab Services. 4. All incidents will be audited daily times 4 weeks, then 5 times a week Monday through Friday times 3 months in AM clinical meeting and/or until 100% compliant by the Director of Nurses for following the policy in the "Falls Management" and "Events Management". The results of those audits will be reported by the Director of Nurses and reviewed at the Quality Assurance/Performance Improvement Meeting monthly. Members are the Medical Director, Administrator Director of Nurses, Social Services, Activity Manager, Dietary Manager, Minimum Data Set Coordinator, Medical Records and Rehab Manager.	10/1/2011

Angela K. Chitwood Administrator 9-1-2011

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F 225	Continued From page 2 dated July 13, 2011, at 8:09 a.m., revealed the resident returned to the facility. Review of facility investigation documentation dated July 13, 2011, revealed the resident's fall was unwitnessed and included, "Incident Type Fall/no head injury...res states reaching for bottom drawer of bedside table and rolled OOB (out of bed)...possible cause...res was reaching for bottom drawer of bedside table and lost balance...Implement: Remove bedside table Fall mat in place..." Continued review revealed, "...Alert and oriented to person only..." Continued review revealed, "I walked into room and seen (resident) wasn't in bed. I went on over and seen...in the floor..." Continued review revealed no documentation regarding staff member responsible for the resident's care at the time of the fall, when/where the resident was last seen and/or the activity the resident was engaged in prior to the fall, other staff/residents' interviews, or the position of the bed. Observation on August 17, 2011, at 1:12 p.m., revealed the resident seated in a wheelchair in the resident's room, next to the resident's low bed and a floor mat on end placed against the front of the resident's bed. Continued observation revealed no visible bruises. Interview with the resident on August 17, 2011, at 1:12 p.m., revealed the resident was not oriented to time or situation. Interview with the Assistant Director of Nursing (ADON) on August 13, 2011, at 2:35 p.m., in an office by the dining room, revealed the ADON completed the investigation documentation dated	F 225		

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F 225	Continued From page 3 July 13, 2011, and the type of incident was in error. Continued interview confirmed the facility failed to thoroughly investigate an injury of unknown origin for Resident #2 on July 13, 2011. C/O: #28407	F 225		